Sample Template **SCHOOL DISTRICT NAME**

SAU phone number (603) 000-0000 Special Education Department

ADDRESS

MEDICAID HEALTH RELATED SERVICES ORDER

DATE:_____ STUDENT _____

DATE OF BIRTH_____ CASE MANAGER:_____

PRIMARY CARE OFFICE:_____

As a licensed treatment practitioner or clinician, practicing within the scope of my board licensure, I recommend the services listed below be provided to the above-named student in accordance with the decisions made by the Individual Education Program (IEP) Team and described in the student's current IEP or written care plan. The IEP Team makes decisions about services based on the impact and nature of the student's disability.

Health related services included in this student's IEP for one year from _____ through_____ are:

- ☐ MENTAL HEALTH EVALAUTION AND/OR COUNSELING
- ☐ FEEDING AND SWALLOWING EVALUATION AND/OR TREATMENT SERVICES
- ☐ REHABILITATIVE ASSISTANCE FOR THE MEDICAL PURPOSE OF: _____
- ☐ OCCUPATIONAL THERAPY EVALUATION AND/OR TREATMENT
- ☐ PHYSICAL THERAPY EVALUATION AND/OR TREATMENT
- ☐ SPEECH/LANGUAGE EVALUATION AND OR TREATMENT
- ☐ VISION EVALUATION AND/OR RELATED SERVICES
- ☐ NURSING ASSESSMENT AND /OT TREATMENT SERVICES
- ☐ AUDIOLOGY/HEARING EVALUATION AND/OR TREATMENT SERVICES
- ☐ DURABLE MEDICAL EQUIPMENT/MEDICAL SUPPLIES (PLEASE LIST) _____

I authorize the identified services and/or evaluations as medically necessary and refer this student to treatment by the IEP Team.

Qualified licensed practitioner name (please print)_____

Qualified licensed practitioner signature _____

Credentials (MD, PA, APRN)_____ Date_____

NPI number_____

I am a NH Medicaid enrolled provider Yes ☐ No ☐

Medicaid enrolled provider number_____